Supreme Court, U.S.
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No. _____

In The

Supreme Court of the United States

October Term, 1996

ANN R. ULCZYCKI, Executor of the Estate of Joseph Ulczycki, Deceased,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether it was possible for the Seventh Circuit to affirm a verdict unsupported by rational evidence based upon this Court's decision in *Anderson v. City of Bessemer,* 470 U.S. 564, and other decisions, or whether the law concerning the powers and duties of a reviewing court was misapplied.

LIST OF PARTIES

The following is a complete list of all parties involved in this litigation:

A. **Petitioner** herein and Plaintiff below: Ann R. Ulczycki, Executor of the Estate of Joseph Ulczycki, Deceased; an individual.

B. **Respondent** herein and Defendant below: United States of America.

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PETITION FOR WRIT OF CERTIORARI

Petitioner Ann R. Ulczycki, Executor of the Estate of Joseph Ulczycki, Deceased, respectfully requests this Court to issue a writ of certiorari to review the judgment of the United States Court of Appeals for the Seventh Circuit entered in this proceeding on June 12, 1996.

OPINIONS BELOW

The Order of the Court of Appeals for the Seventh Circuit is unpublished and unreported pursuant to Circuit Rule 53 and is reprinted in the Appendix at App. 1-7. The Judgment of the United States District Court for the Northern District of Illinois, Eastern Division, was entered on December 1, 1995 without the filing of any written opinion or memorandum. [App. 8] The district court did however make certain findings from the bench at the time of its ruling, which were transcribed and included the report of proceedings. This is reprinted in the Appendix at App. 9-22.

JURISDICTION

On June 12, 1996, the United States Court of Appeals for the Seventh Circuit entered its order affirming the decision of the district court. [App. 1-7] The Circuit Court of Appeals' jurisdiction was based on 28 U.S.C. §1291. Petitioner filed a timely Petition for Rehearing which was denied on August 30, 1996. [App. 23] A timely application to this Court for additional time to and including December 18, 1996 for the filing of the instant Petition was made and allowed on November 22, 1996. Consequently, Petitioner invokes this Court's jurisdiction under 28 U.S.C. §1254(1) and 28 U.S.C. §2101(c).

STATEMENT OF THE CASE

Procedural History

This is a Federal Tort Claims Act case filed on December 30, 1994, arising out of two hospitalizations at Hines VA Hospital in April 1991, resulting in the death of Joseph Ulczycki, age 69, at Loyola University Medical Center on

April 29, 1991, caused by death of his intestines. The case was tried before the Honorable George Lindberg without a jury on November 27 through 29, 1995. The court made findings on November 29, 1995, finding that there had been no breach of duty of standard of care and entering judgment for the defendant on the same date. [R.511, vol.III, App. 8, 9-22] Appeal was taken to the Seventh Circuit Court of Appeals, which entered a non-published order affirming on June 12, 1996. [App. 1-7]

The Evidence in the Case

At trial numerous witnesses testified in addition to Plaintiff and decedent's children. Plaintiff-Petitioner's expert was Dr. Kenneth Bennett, while Dr. John Weigelt was the expert for the Defendant – Respondent. Additionally, treating and attending physicians testified who included Dr. Fred Littooy, Dr. Mark DeMeo, Dr. Charles Tattersall, and Dr. Michael Cohen, an intern who was solely in charge of Joseph's care at the time when his illness reached its crisis.

Dr. DeMeo testified regarding the general presentation, cause and treatment for chronic mesenteric ischemia [CMI] and acute mesenteric ischemia [AMI]. The terms mesenteric ischemia and ischemic bowel disease are used interchangeably. Joseph had a history of hematochezia (passing of blood from the rectum), diarrhea, chills, vomiting, abdominal pain, malaise, fever and poor appetite. [R.288-289, vol.II; Def.Ex.H. 463, 449, 447, 444, 416, Ex.vol.11] These symptoms are consistent with ischemic bowel disease. [R.292-293, vol.II] Ischemic bowel disease was in the differential diagnosis during the first admission. [R.290,308, vol.II]

From April 14, 1991 to April 21, 1991, Joseph had mesenteric ischemia. [Plaintiff's Proposed Finding of Fact #2&3, p. 27, Doc. 23][1] Dr. Kenneth Bennett, a board certified general surgeon, testified as plaintiff's expert witness. He testified that

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[1] All proposed findings were made part of the evidentiary record of this case pursuant to a district court order entered December 1, 1995. [Doc. 24]

mesenteric ischemia means insufficiency of blood to the intestines. [R.204, vol.II] An arteriogram (also referred to as an angiogram) is needed to confirm a diagnosis of CMI. [R.157, vol.I] Definitive treatment of colonic ischemia is surgical. [R.405, vol.III] If Joseph had had surgery for CMI during the first hospitalization, he would have survived. [R.240-241, vol.II] He was released from the hospital on April 19, 1991 with the diagnoses of peptic ulcer disease and presumptive staph food poisoning [Def.Ex.H.464, Ex.vol.11].

Joseph was readmitted to the Gastroenterology Service at Hines VA Hospital on April 21, 1991, with symptoms which were very similar to the symptoms of the previous admission. [R.302-303, vol.II; Def.Ex.H.602,458, 457, 597, 595, Ex.vol.11]. His abdominal pain was related to eating, which is typical for CMI. [R.133-135, 303-04, 331-32, vols.I&II] He was again seen by Dr. DeMeo.

The Peripheral Vascular Surgery Service was first consulted on April 22, 1991. [Def.Ex.H.571,587,589, Ex.vol.11] Initially, Joseph was seen by Dr. Charles Tattersall, a vascular surgery fellow. [R.339, vol.II] Upon recommendation of the Peripheral Vascular Service, Joseph had an angiogram on April 24, 1991. It was Dr. Bennett's opinion that the Peripheral Vascular Service should have been contacted earlier, which would have resulted in the angiogram being done by April 23. [R.258, vol.II]

The angiogram was performed and interpreted by Dr. Subramanian Ramamurthy, a diagnostic radiologist. The angiogram demonstrated complete occlusion of the superior mesenteric, inferior mesenteric and celiac arteries that ordinarily supply blood to the bowel, which was an unusual case. [Vol.IX – 9, R.46, Def.Ex.H.586] With all three of these occluded, Joseph was at high risk to develop AMI, which could occur without warning. [Ex.Vol.IX, 23-24; R.125-126, vol.I] Joseph had blood supply to his bowels from a single, small, very tortuous, backward-flowing collateral which led to the intramural vessels (going into the bowel wall) which Dr. Ramamurthy saw very faintly. [Vol.IX at 32,35,37,67-68] Dr. DeMeo described this as pretty tenuous collateralization. [R.312,319-320, vol.II]

Dr. Fred Littooy was the Chief of the Peripheral Vascular Service and Joseph's attending vascular surgeon. [R.102, vol.I] He was the physician at Hines most capable of determining whether a patient was going from a chronic to acute situation. [R.124-125,369,388, vols.I&II] Dr. Littooy and Dr. Tattersall were aware of the significance of the angiogram findings of marginal circulation to the intestines. [R.109-110, 126,131-132,137-140,159-163,376, vols.I&III]

Joseph needed surgery to revascularize his intestines. [R.112-113,135 136,313,314, vols.I&II] The purpose of therapy for mesenteric ischemia is to prevent progression to abdominal findings and infarction of the intestine. [Plaintiff's Proposed Findings of Fact #7&8, p. 27, Doc. 23] Joseph was at high risk to suddenly go into an acute phase. [R.125-126,137,147, vol.I] When he would go acute was unpredictable, could occur in an instant, and there was no guarantee it would not happen the next day. [R.375,429-30, vols.II&III] The goal was to get the surgery done before he went acute. [R.142,166,374,375, vols.I&II] If he went acute, it would be a catastrophe and he would probably die. [R.377, vol.II]

Dr. John Weigelt, a surgical and critical care expert for the defense, testified that AMI is a life-threatening vascular emergency [R.439, vol.III] Dr. Bennett had previously defined elective surgery as surgery that could be done at any time and "urgent" as needing to be done as soon as possible before damage takes place. [R.205-207, vol.II] Dr. Weigelt opined that the surgery was scheduled as elective, while the poor visualization of the intramural vessels on the angiogram indicated a highly ischemic lesion which put Joseph in the urgent or emergent surgical category. [R.435, vol.III] Dr. Weigelt testified that Joseph had the worst possible case of CMI. [R.417, vol.III] Dr. Bennett agreed that surgery was urgent at this time. [R.233, vol.II] If Dr. Littooy had understood this to be an emergency on Thursday or Friday, he would and could have done the surgery then. [R.113,150-151, vol.I] Dr. Weigelt opined that if the operation had been done on Friday or Saturday, Joseph probably would have had a revascularized intestine and survived. [R.446, vol.III]

The operating room at Hines was going to be shut down from the afternoon of Friday, April 26 through Sunday, April 28. [R.114,148,151, vol.I; Def.Ex.G][2] Dr. Littooy knew there would be a 2 to 3 hour delay getting Joseph to an operating room if an emergency occurred over the weekend. [R.149-150, vol.I] Joseph and his family were not told about the operating room being closed for the weekend. [R.153-154, vol.I] The surgery was scheduled for the following Tuesday, April 30, because it was Dr. Littooy's regular operating day and the next elective day at Hines. [R.112-113,147, vol.I] Dr. Tattersall testified that the surgeons took a calculated risk that the marginal circulation to Joseph's intestines would be maintained until Tuesday. [R.376-377, vol.II] If the arteriogram had been done during the first hospitalization, it would have showed the same thing and Dr. Littooy would have scheduled him for the next elective operative day. [R.111-145, vol.I] If he had his operation before he went acute, he had a 85 to 90% probability of survival. [R.345,388-389, vol.II] A thallium treadmill test was performed on April 26, 1991, because the planned operation could cause stress on the heart. [R.110, vol.I; Def.Ex.H.523,579, Ex.vol.11] After the test was done, there was nothing else to do to prepare Joseph for surgery. [R.445 446, vol.III]

Dr. Michael Cohen testified regarding his activities as a physician seeing Joseph over the weekend of April 27 to April 28. Dr. Cohen was an intern in April 1991, his first year out of medical school. [R.16-17, vol.I] He stated that he was there to learn. [R.22,59,64, vol.I] From approximately 7:00 a.m. Saturday, April 27 until the morning of Sunday, April 28, he was Joseph's only doctor. He was told to keep watching Joseph and see if anything changed. [R.60,64, vol.I] Dr. Littooy assumed Dr. Cohen, Tattersall or Thomas would call him if there was any sign Joseph was going acute so that Dr. Littooy could

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[2] The sequence of events which follows the closing of the operating room are highly significant to the understanding of this case. To make them clearer, a chronological chart has been prepared appearing at Appendix at 24-25.

decide if Joseph needed an operation sooner. [R.147,42-43, vol.I] Littooy had no way of knowing what was going on over the weekend unless he was called. [R.128-129, vol.I] Littooy was not contacted before Sunday afternoon, April 28. [R.151.vol.I]

Although Dr. Cohen was not an expert, he knew generally about CMI and AMI, and that AMI was a life-threatening surgical emergency. [R.17 18,24,27 28, 58 59, 61 62,69 70,73 74, vol.I] Dr. Cohen was aware of the angiogram findings. [R.53,129-130, vol.I; Def.Ex.H.601-602, Ex.vol.11] At 6:00 p.m. on Saturday, April 27, 1991, Joseph had sharp severe epigastric pain and mild epigastric tenderness on physical exam. [Plaintiff's Proposed Findings of Fact #24. Doc. 23; R.24,26; Def.Ex.H.578,580, Ex.vol.11]. He was in terrible pain, rolling around in the bed. [R.90-99, vol.I] This pain continued through the night and into the morning. [R.57-58, vol.I; Def.Ex.H.601-602, Ex.vol.11] Dr. Cohen considered the possibility that his symptomatology was due to mesenteric ischemia [R.24 vol.I]. He knew that prior tests showed no bleeding ulcers, that he was scheduled for surgery for CMI and that he was on intravenous medication that would make it less likely he would have acute ulcer pain. [R.22,25,33, vol.I] Dr. Cohen, concerned about a possible perforated ulcer, treated Joseph for an exacerbation of peptic ulcer disease by giving Mylanta, which did not help. [R.29,31-32, vol.I] But the evidence conclusively showed that if he had a perforated ulcer, his abdomen would have been "board-like." [R.304, vol.II] It was negligent for Dr. Cohen not to recognize this as an ischemic problem. [R.217-218, vol.II] At 6:00 p.m., Dr. Littooy should have been contacted. [R.263-264, vol.II] An emergency existed which continued to the next day. [R.235, vol.II]

At 8:30 p.m., Joseph still had pain. Dr. Cohen gave nitroglycerine for an unlikely cardiac problem, which did not help. [R.31, vol.I] He also gave Benadryl to relax Joseph so he could sleep, but that did not work. [R.33-34, vol.I] At 1:30 a.m. on April 28, Dr. Cohen prescribed Demerol and Vistaril for pain relief and to relax him. [R.36-38, vol.I] Significantly, this is the very same time when the district court found that the bowel was starting to die.

On April 28, 1991 at 6:00 a.m., Joseph had severe abdominal pain, fever, high blood pressure, rapid heart rate and rapid pulse. [R.40,44-45, vol.I; Def.Ex.H,576, 577, 484]. At trial, Dr. Littooy testified that this was an acute change and had he known about it, he would have considered it an emergency and would have begun steps toward surgery then. [R.151-153,167,169, vol.I] It is a mistake to wat.a a patient with CMI until he has abdominal findings on exam before being concerned about him being in an acute phase. [R.140-141,168-169,437-439, vols.I&III]

According to the family, by Sunday morning, Joseph was incoherent, writhing in bed and saying "Oh my God". [R.92-93,178-179,190-191, vol.I] At 10:00 a.m., Joseph had labored respirations and severe abdominal pain, for which Dr. Cohen prescribed Demerol and Vistaril. [R.47-48, vol.I] If the decision to operate had been made by then, he could have been in surgery by noon. [R.361-362, vol.II] If Joseph had the surgery by 10:00 a.m., he had at least an 85-90% probability of surviving without loss of any bowel. [R.241-242, vol.II] At 10:20 a.m., Dr. Cohen ordered an abdominal X-ray to look for a perforated ulcer or an exacerbation of ischemia. [R.49 50, vol.I] This would have been a "quick first step" at 6:00 a.m. and could have been done "stat". [R.153, vol.I] This was an emergency, and it was negligent not to order the X-ray "stat". [R.239, vol.II]

Dr. Tattersall testified that he was called April 28 in the afternoon and was told that the pain was worse than it had been. He suggested an X-ray. [R.357-358, vol.II] The X-ray, done at 2:00 p.m., showed gas in the portal vein, which was a very bad finding, a surgical emergency. [R.358-59,372,405 406, vols.II&III] Joseph was gravely ill, and toxic. [R.359, vol.II] Dr. Tattersall then learned that the operating room at Hines was not available. [R.359-360, vol.II] After the X-ray, the family was informed that the operating room was shut down for the weekend and that the doctors would try to transfer Joseph to West Side VA. [R.94, vol.I]

West Side VA is 20 minutes away by ambulance, while Loyola is right across the street from Hines. [R.149, vol.I] Joseph was transferred to Loyola for emergency surgery at

5:15 p.m. and was in surgery at 6:05 p.m., after Dr. Tattersall had been unsuccessful in attempting to transfer him to West Side VA Hospital. [R.360,366, vol.II] At the time of surgery, Joseph Ulczycki had extensive bowel death and was not expected to survive; he died at 4:00 a.m. on April 29, 1991.

The District Court's Judgment

Upon close of evidence, the district court announced judgment for the Defendant, and made a number of specific findings. These included that all the witnesses had testified honestly and were credible, but that he did not give much weight to the testimony of Dr. Tattersall and he was inclined to prefer the testimony of doctors Weigelt and Littooy to that of Dr. Bennett because it believed them to have greater hands on experience. [App. 13] The district court found that there was no breach of standard of care from the time of Joseph's initial admission at Hines VA through the following Wednesday of his second admission. It found further that it was not below the standard of care to treat Joseph's condition as urgent rather than an emergency, nor was it improper to schedule Joseph's surgery for the following Tuesday, since Dr. Littooy would be available to perform it on that day. The Court further found that there was no emergency situation prior to 6:00 a.m. on the morning of Sunday, April 28, 1991. It found further that "things started happening" at about 1:30 that morning and that a surgery commenced as early as 7:00 on Sunday morning would not have saved Joseph's life.

The Order Of The Court Of Appeals

The Court of Appeals, in affirming, stated that careful surgeons would not have diagnosed acute ischemia prior to 6:00 on the morning of Sunday, April 28, 1991, but by that time it was too late to save the bowel. [App. 6] The Seventh Circuit further observed that epidemiological evidence would be required as a basis for any determination that it was breach of duty to treat the surgery as elective, and that no such evidence had been offered by either party. [App. 5] Accordingly, the conclusion was reached that the record did not show

that the judgment was clearly erroneous, and it was consequently affirmed.

A timely Petition for rehearing was filed on July 29, 1996, and denied on August 30, 1996 [App. 23]; this Petition resulted.

REASONS FOR GRANTING THE PETITION

In the leading case of *United States v. U.S. Gypsum*, 333 U.S. 364 (1947), this Court undertook to define what was meant by a "clearly erroneous" determination as that term is used in the federal rules, holding that it did not mean that there is no evidence to support a judgment, but rather that it is clearly erroneous when the reviewing court, on the entire evidence, is left with the definite and firm conviction that a mistake has been committed. [*Id.* at 395] Pursuant to that rule, this Court has exercised its authority, both in *U.S. Gypsum* and subsequently, to reverse lower court determinations which have failed to be consistent with this Court's understanding. *McCain v. Lybrand*, 465 U.S. 236, 257-58 (1984) Petitioner respectfully submits that the case at bar is such as warrants this Court's intervention, pursuant to the rule and authority of *United States v. U.S. Gypsum*, because any fair consideration of the evidence as a whole demonstrates conclusively that the judgment for the Government was mistaken, is not supported by the record, and that the lower courts reached their conclusions by means which were neither proper nor judicial.

Considering the number of witnesses called and the amount of medical evidence received, there was surprisingly little actual contradiction in the substantive evidence offered. Most of the contradictions came between various witnesses called by Defendant, with the treating doctors often disagreeing with each other or with the defense expert. On very few occasions did they disagree with the Plaintiff's theory or the Plaintiff's expert, Dr. Bennett. This is one of the features which makes the district court's decision so surprising. There is no controversy about the central fact of this case: Ulczycki was admitted to Hines V.A. Hospital where he died a week

later for want of a six to eight hour operation which would have unquestionably corrected his condition and saved his life.

There are some facts about which there is no controversy whatsoever. First, Joseph suffered from a disease, chronic mesenteric ischemia [CMI], which a relatively safe and uncomplicated operation would almost certainly cure, giving him years of additional life. [R.345,388,389, vol.II] There is no controversy about that fact. Next, CMI can become acute [AMI] at any moment, and when it does so immediate surgical intervention is necessary to avoid death. [R.142,166,374-375, vols.I&II; R.377, vol.II] There is no controversy about that fact. Next, the medical evidence was in agreement that from the time the condition became acute until the time his bowel died was between six and eight hours. The medical evidence was also in agreement that in an emergency operation the bowel could be revascularized within four and five hours. [R.167, vol.I] Hence, the record shows that there was a window of opportunity to save the bowel, and with it the patient's life, if the operation is done quickly enough. On the other hand, the evidence was also uncontradicted that in the exercise of standard of care, a physician knowing of the presence of CMI should never wait for the condition to become acute before beginning the operation. Rather, there is a "golden hour" of opportunity before the mesenteric ischemia becomes acute, when the surgery should be commenced. This pre-acute phase is characterized by extreme abdominal pain but no other objective symptoms. [R.439, vol.III] All the medical evidence offered agreed on this point.[3]

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[3] Dr. Weigelt, the Respondent's own expert, explained that AMI can be identified before bowel infarction develops. [R. 439, vol. III] He testified: "The physician [i.e., Dr. Cohen] suspecting the presence of AMI, but unsure of the source of pain must be willing to pursue the problem aggressively without waiting for more positive signs to develop. [R. 437-38, vol. III] . . . That point cannot be over-emphasized because it is precisely during this period of observation that the opportunity to save the patient may be lost. [R. 438, vol. III] . . . By the time the tell-tale signs of peritoneal irritation become evident on abdominal palpitation [sic] or the plane [sic] film is positive for ischemic bowel, intestinal necrosis usually

As for Ulczycki's condition and circumstance, the evidence is largely in agreement. The record showed clearly that Ulczycki's blood supply to his bowel was highly compromised, tenuous and marginal at best; the entire bowel being serviced by a single collateral vessel. [Vol.IX at 32, 35, 37, 67-68; R.312, 319-320, vol.II] Of this situation, there was no disagreement, from any source, with Dr. Ramamurthy's opinion that it was an unusual case. [Vol.IX-9, R.46, Def.Ex.H.586] In fact, Dr. Weigelt described Ulczycki as having worst kind of case. [R.417, vol.III] Accordingly, all medical evidence agreed that Ulczycki was in such a condition that he could become acute at any moment. [Ex.Vol.IX, 23-24; R.125-126, vol.I] There is no question that when Ulczycki was admitted to Hines V.A. for the second time that week, cancer and other possible sources for his complaint had already been excluded. The manifest weight of the evidence showed that Ulczycki required surgery on an urgent basis as early as the middle of that week [R.205, 207, vol.II; R.435, vol.III],[4] but that his doctors decided to take a "calculated risk" and delay the surgery until the following week – leaving him to lie in a hospital in which the operating rooms had all been closed for repairs. [R.376-377, vol.II; R.114, 148, 151, vol.I; Def.Ex.G]

There was no conflict in the evidence as to what happened on the night of Saturday, April 27. Ulczycki had been left under the care of Dr. Cohen, a first year intern, who had been instructed to notify his superiors if there was any change. [R.60, 64, vol.I] Dr. Littooy, Ulczycki's treating physician,

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has developed, drastically reducing the patient's chances of survival. [R. 438, vol. III] . . . The point that must be remembered is that acute, severe abdominal pain in the absence of other abdominal findings is often the clearest sign of early preinfarction ischemia indicating the golden moment for aggressive intervention." [R. 439, vol. III] Dr. Littooy essentially testified to the same thing when he stated that it would be a mistake to watch a patient with CMI to wait until the patient has abdonimal findings on exam before being concerned about the patient being in the acute phase. [R. 140, vol. I]

[4] And the District Court specifically found that his condition, while not an emergency, was urgent. [App. 15]

stated clearly that he expected to be informed of any change of condition. [R.147, 42-43, vol.I] There was no controversy about any of this. At about six o'clock that evening there was a marked change in condition. At that time Ulczycki began to suffer severe and finally unbearable abdominal pains. [Def.Ex.H.578,580, Ex.vol.11] This was the classic presentation for a CMI patient who was not yet, but would soon go acute. Dr. Cohen testified that he knew that these were the symptoms of impending infarction (bowel death), and that he knew that Ulczycki was a CMI patient awaiting corrective surgery. However, Dr. Cohen did not take any action with respect to CMI or AMI, but rather treated Ulczycki for ulcers [R. 29, 31-32, vol.I], even though the medical evidence was clear that he made no presentation for ulcer problems at that time. [R.304, vol.II] After spending several hours trying to treat Ulczycki for ulcers, Dr. Cohen undertook to treat him for a cardiac problem, thinking that might be the source of his abdominal pain. [R.31. vol.I] This also failed to help Ulczycki, who was now rolling around on the bed screaming, so Dr. Cohen doped him up so he could get some sleep. [R.90-99, vol.I; R.33-34, vol.I] There is absolutely no controversy about any of this. There is also no controversy about the fact that Dr. Cohen never called Dr. Littooy or any of his superiors.

It is not until the next morning, at 6:00 a.m. that there is any real conflict in the evidence. Dr. Littooy testified that at 6:00 a.m. on Sunday Ulczycki was in an emergency situation. [R.151-153,167,169, vol.I] Dr. Cohen, on the other hand, testified to an absence of findings which would indicate that infarction had begun [R.43, vol.I], while Dr. Tattersall testified that, in his opinion, Ulczycki's condition was nothing to be concerned about. [R.356, vol.II]

From this record the district court inexplicably concluded that at 6:00 a.m. there was no longer time to save the bowel. Such a finding, albeit unsupported by the evidence, had the effect of excluding from inquiry all that transpired at Hines during the remainder of the day. At least eight more hours were to pass before Dr. Littooy was even notified of what was going on. The x-rays which he would have ordered to be taken immediately at 6:00 a.m., had he known what was happening,

were not taken for another eight hours, and even four hours after Dr. Cohen got around to ordering them. [R.239, vol.II] The x-rays showed that the infarction (bowel death) was in progress, yet it took another four hours for Ulczycki's doctors to find him an operating room in another hospital and commence the operation. By the time they opened him up – 12 hours after his condition was an emergency and at least sixteen hours after he had made the classic presentation of that golden moment for surgical intervention – the bowel was finally dead and there was nothing further which could be done. Given these uncontroversial facts, it is impossible, Petitioner submits, for the finding of no negligence to be anything other than a mistake.

Plaintiff strenuously maintains that the standard for reversal has been met in the case at bar. The district court's conclusion that there had been no negligence on Defendant's part, and those findings upon which that conclusion was tenuously based, are entirely unsupportable under any fair reading of the record in this case. All the doctors agree that CMI is a condition which can go acute at any moment. Dr. Weigelt, the Defendant's expert, pointed out how serious a case Joseph presented. And it was he who said that if Joseph's angiograms presented poor visualization (and they did) he needed to be treated urgently. Yet the doctors dallied. No medical reason is offered for waiting to refer Joseph to the peripheral vascular service; and while everyone agrees that it was proper to do a thallium stress test before surgery, no one suggested a medical reason for waiting till Friday to do it – Joseph had been in the hospital the whole week. Likewise the evidence is undisputed that, after the cardiac work-up, Joseph was cleared for surgery, and would have survived if they had done the surgery that Friday, which Littooy said they could have done, before the operating room was shut down. But rather they elected to postpone the surgery into the following week, even though everyone agreed that Joseph's blood flow to the bowel was slow, even marginal, and that he could go into acute at any time. And why did they decide to wait – the evidence is clear – for their own convenience, so that Dr. Littooy could perform the surgery on his regular day. Dr. Tattersall was very frank

about it: they were taking a calculated risk – they were hoping the marginal blood flow would hold up till Tuesday. But what factors were involved in this calculation? Clearly only administrative convenience against the life of their patient. Hence, Dr. Littooy's blase remark: "Life is the way it is." [R.149, vol.I]

And then we come to Saturday night. Dr. Cohen, a first year intern, is left alone with the patient without instructions. True, Dr. Littooy said he expected to be called if there was any change, but he probably didn't count on Joseph being left with someone who would treat for ulcers when there was no presentation for ulcers, such had been excluded in his differential diagnosis, he's waiting for surgery for mesenteric ischemia, but that's never looked into. In addition to not looking for ischemia in an ischemia patient, Dr. Cohen also did not look for a phone. Exactly why a patient who was in the hospital for a condition which even Dr. Cohen knew could become acute at any moment, who had gone from a more or less stable condition to being in such pain he had to be drugged to the gills, did not merit a phone call to the attending physician ought to have been addressed before the district court gave judgment to the Defendant. Not that the matters improved the next day. Dr. Littooy said that if only he had known he would have rushed Joseph into surgery, and that there was certainly an emergency situation by 6:00 in the morning, and that Joseph needed an x-ray *stat.* to determine, not whether the surgery was needed, but how far the attack had gone. But Dr. Cohen, when he finally orders the x-ray, does not order it *stat.*, and it doesn't get done for four hours, which was enough time to have done the operation. Then they finally decide to call Dr. Littooy, after clear evidence that the bowel has started to die. Who testified that it was the standard of care to wait till you could clearly see that the bowel had started to die before calling the attending physician and start to think about an emergency surgery? No one. On the contrary, all the testimony was that you must get the surgery started before the patient goes acute. But that's not done. The surgery comes too late. It takes six to eight hours for the bowel to die, Joseph is in the hospital the entire time. He's there because the doctors know that this is what is going to

happen to him unless there is a surgical intervention. There's nothing uncertain about his prognosis if he has a timely operation – he will live. If he goes acute and does not have surgery, he will die. Well, he does become acute. Is it a defense that nobody at Hines knows how or when? He was under their care the whole time. On Friday he was merely chronic, on Monday he was dead, dying of the very disease he came in to be treated for. But nobody at Hines knows when he became acute. Would it be too much to expect that if he'd been properly treated they might know? But there is still a substantial window of opportunity to save him. The bowel does not die immediately and it does not die all at once, there are many hours to work with. But that precious time was squandered. He's given Mylanta, he's given nitroglycerine, he's given pain killers, but what else can you do in a hospital that has no operating room and where no surgeries can be performed? Perhaps that's why the intern didn't bother to call Dr. Littooy. But the bottom line is this. The district court's decision amounts to a finding that where a patient has a chronic condition subject to becoming suddenly acute, in which even he must have surgery or he will certainly die, the standard of care is not breached by failing to observe that he is becoming acute, or by thereafter delaying the operation for half a day. Somehow, in this case, it became acceptable not to provide available life saving treatment because an intern doesn't bother to advise the doctor about a change in condition. Plaintiff asks this Court: what more could Defendant have done *not to treat* her husband: everything was first delayed and then ignored. When it takes the bowel six to eight hours to die, how, in the absence of negligence, do you not begin surgery on a hospitalized patient until it's too late? There is no way. It is manifest that the district court's finding that the Respondent was free from negligence, and the Seventh Circuit's approval thereof, were clearly mistaken.

Having considered the background generally, let us consider some of the specific findings of the district court and the Seventh Circuit. It is Petitioner's position the district court's findings are logically and internally inconsistent and cannot possibly be correct under the evidence. The findings, which the district court itself declared to be "critical," are these: (1) that

up until 6:00 a.m. there was *as yet no medical emergency* with respect to the ischemia, which the court continued to describe as chronic; and also (2) that at 6:00 a.m. the bowel was already past saving, so that no surgical intervention, even if begun as early as 7:00 a.m., would have made any difference. [App. 19] These two findings cannot exist together under the uncontradicted evidence in this case, for the uncontradicted evidence, and the well established scientific fact, is that it takes a considerable number of hours for the bowel to die, which process does not itself begin until after the patient's condition has become acute. It was agreed by all witnesses who gave any testimony on the subject that the bowel takes between 6 to 8 hours to die *after* the acute phase begins. [R.152, vol.I] Therefore, it is impossible for the emergency condition to commence and the bowel death to be simultaneously complete under this evidence. It cannot be true that there could be no medical emergency before 6:00 a.m. and that at 6:00 a.m. the bowel had deteriorated so far that it was past saving, because it takes the bowel six to eight hours to die.

But while both findings cannot be correct under the evidence, the district court was correct when it declared that they were critical, for the first finding, that there was not yet an emergency before 6:00 a.m. on Sunday morning, makes irrelevant all that went before, particularly the conduct of Dr. Cohen, for which no witness was able to make excuse and which was condemned by Dr. Bennett, Dr. Weigelt and Dr. Littooy alike. If, however, there was no emergency before 6:00 a.m., what happened after that hour, the delays in contacting Dr. Littooy, in performing the x-rays, in securing an operating room, are clearly of the greatest significance, or would have been had the district court not made the second irreconcilable part of its finding: that at 6:00 a.m. the bowel had deteriorated past the point that it could be saved. Hence, the district court's findings, while themselves inconsistent and impossible under the evidence, have the remarkable effect of excusing anything which happened both before 6:00 a.m. and after that time, since none of the complained of conduct (at least since Saturday night) could have proximately caused the result. Even the district court's statement that it found no breach of duty is

parasitic upon these findings, for, while the district court did not elaborate upon the subject, clearly it found there was no breach of duty in failing to diagnose or react to an emergency before 6:00 a.m. because there was no emergency before 6:00 a.m.; likewise, it found there was no breach of duty in thereafter delaying a useless operation. Accordingly, Plaintiff respectfully submits that this entire case turns upon those inconsistent and illogical findings, which cannot possibly be correct under the undisputed evidence.

It is for this reason that the Seventh Circuit's reliance upon *Anderson v. City of Bessemer,* 470 U.S. 564, is misplaced. [1985] That case is cited for the proposition that where the finding is based upon a trial judge's decision to credit the testimony of one or more witnesses in preference to that of others, such can virtually never be clear error. But, the same language also announces the existence of exceptions to this rule, and one of those is findings that are internally inconsistent [*Id.* at 575], and that is exactly what is presented to this Court in the case at bar, as a review of the evidence clearly shows. Not only are the district court's findings internally inconsistent and impossible because of the evidence with respect to how long it takes for the bowel to die, they are unsupported by the evidence in the case. With respect to the issue of when the ischemia became acute and what the outside limits for surgical intervention were, most of the medical witnesses had something to contribute. Dr. Bennett believed that there was an emergency as early as 6:00 p.m. on Saturday night. [R.217-18, 263-64, 235, vol.II] This does not support the district court's finding that up until 6:00 a.m. on Sunday morning there was not yet an emergency. Dr. Bennett also testified that if surgery had been done by 10:00 a.m., Joseph's life might have been saved. [R.241-42, vol.II] This does not support the district court's finding that surgery, even if it was begun by 7:00 a.m., would come too late. Dr. Weigelt's testimony similarly does not support either finding. He testified that, in his opinion, the case was emergent as early as Thursday, April 25, as soon as they got the angiogram results, and saw how reduced the blood flow really was. [R.435, vol.III] He also testified that successful surgery could have started as late

as noon on Sunday, April 28. [R.411-12, vol.III] Hence, the testimony of Dr. Weigelt does not support either of the findings. Dr. Cohen had no opinion as to when the last possible surgery could have been done, and hence his testimony cannot be said to support the finding that 7:00 a.m. would have been too late. He did testify to an absence of physical findings on examination at 6:00 a.m., which means that infarction had not yet begun. [R.43, vol.I] Accordingly, his testimony does not support the district court's finding that the bowel was dead at 6:00 a.m., rather he contradicts it. This finding is also contradicted by Dr. Tattersall, who indicated that, to his mind, Joseph looked pretty good at 6:00 a.m., [R.359, vol.III] as opposed to how had he looked at 2:00 in the afternoon.[5] [R.357 59, vol.III] His testimony, accordingly, does not support the conclusion that the bowel was dead at 6:00 a.m., although it would support the finding that at 6:00 a.m. the crisis had not yet been reached.

Dr. Littooy, on the other hand was very certain in his testimony that by 6:00 a.m. that crisis had been reached, and that Joseph's condition was an emergency. He testified that had he known of Joseph's condition at this time he would have ordered surgery at once. Hence, Dr. Littooy's testimony does not support the district court's finding that there was not an emergency before 6:00 a.m., nor that the bowel was deteriorated beyond any hope of saving by 6:00 a.m. Dr. Littooy did not testify that the bowel was dead at 6:00 or so deteriorated that even surgery begun at 7:00 could not save it. It was his testimony that, based on the conditions at 6:00 on Sunday morning Joseph required emergency surgery. Such a condition, a hopeless and useless procedure, is not an emergency under any reasonable understanding of that term. Such testimony could never support the finding that the bowel was already too far gone to be saved, let alone already dead. Accordingly, we

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[5] It should be noted that between 6:00 a.m. and 2:00 p.m. is an eight hour time span, enough time for the infarction process to entirely take place. It is also enough time for the revascularization process to be done, since, according to Dr. Littooy, it took significantly less time for the revascularization to be done (four to five hours), than for the bowel to die (six to eight hours). [R.167, vol.I]

are not presented with the case where, between various witnesses, each of whom have told a coherent and factually plausible story, the court has based its finding on the testimony of any one of them. There is absolutely no testimony that the bowel was dead at 6:00 a.m. and could not have been saved even if the surgery was started by 7:00. In short, not only are the district court's findings self contradictory, they are without support in the evidence.

With respect to the finding that the bowel was past saving at 6:00 a.m. and that even starting at 7:00 a.m. would have been unavailing, there is simply no such evidence. With respect to the finding that Joseph's condition was, prior to 6:00 a.m., never an emergency, there is only the scantiest of evidence. Hence the unavoidable conclusion is that, apart from the fact that the findings are internally inconsistent, they are unsupported by the record. Such a record required that the Seventh Circuit hold that the judgment is clearly erroneous. *Lame v. United States Department of Justice,* 767 F.2d 66, 70 (3d Cir. 1985). Its failure to do so constitutes a departure from well-established principles, and conflicts with the Third Circuit's ruling in *Lame.*

While Respondent may wish to take refuge in the argument that Dr. Weigelt voiced the general conclusion that he saw no breach of duty, such testimony will not preserve the judgment in a case such as this, where the basic facts compel the opposite conclusion. The rule has been expressed by the Tenth Circuit that when the ultimate or bare conclusions found by the trial court are inconsistent with basic facts of the case, the judgment will be deemed clearly erroneous. *Pendleton v. Pan American Fire and Casualty Co.,* 317 F.2d 96, 101 (10th Cir. 1963); corrected: 326 F.2d 760 (10th Cir. 1964). It is, moreover, recognized that where the opinions or conclusions of the witnesses are unsupportable given the record as a whole, such testimony will not preserve a judgment otherwise unsupported. This arises when such conclusions are entirely contrary to other undisputed evidence in the case. *Legrand v. Trustees of University of Arkansas,* 821 F.2d 478, 481-82 (8th Cir. 1987). It is undisputed that Joseph did not have an ordinary case of

CMI, but among the worst kind of case. [R.417, vol.III] It is undisputed that when his doctors decided to take the "calculated risk" of not scheduling his surgery until the following Tuesday, they knew that there would be no emergency room available at Hines over the weekend, in which to commence emergency surgery if such were needed. [R.114, 148-51, vol.I] It is undisputed that Joseph was, from Saturday night through Sunday morning attended only by Dr. Cohen, a first year intern. [R.60, 64, 151, vol.I] It is undisputed that Dr. Littooy expected to be notified if there was any change in Joseph's condition. [R.147, vol.I] It is undisputed that Dr. Cohen had instructions to call his superiors if there was any change in Joseph's condition. [R.60, 64, vol.I] It is undisputed that there were dramatic changes in Joseph's condition during that night and the early hours of Sunday morning. It is undisputed that Dr. Cohen contacted no one, and no other doctor attended Joseph until the rounds next morning. [R.151, vol.I; R.326, vol.II] It is undisputed that Dr. Cohen knew that Joseph had CMI and was scheduled for surgery for that condition – not for ulcers. [R.22, 25, 33, vol.I] It is undisputed that once a CMI patient goes acute, surgery must be done immediately if his life is to be saved, and that the patient can go acute suddenly and without warning. [R.125-6, 137, 147, vol.I] It is undisputed that Joseph did not present the symptoms for perforated ulcers (a rock hard abdomen) but did present the symptoms of a CMI patient moving toward the acute stage: great pain without objective abdominal findings. [R.304, vol.II; R.437 39, vol.III] It is undisputed that even Dr. Cohen was aware of that fact, [R.24, 28, 61-62, vol.I] and yet it is also undisputed that Dr. Cohen spent Saturday night treating Joseph for perforated ulcers. All of these things are undisputed; accordingly, the Seventh Circuit's determination of these issues constitutes a departure from the rules of appellate review announced by the Tenth Circuit in *Pendleton v. Pan American Fire and Casualty Co.*, 317 F.2d 96, 101 (10th Cir. 1963); corrected: 326 F.2d 760 (10th Cir. 1964) and the Eighth Circuit in *Legrand v. Trustees of University of Arkansas*, 821 F.2d 478, 481-82 (8th Cir. 1987).

Legrand was a discrimination case, and, pursuant to testimony from the defense, the district court concluded that there was no discriminatory intent, that the plaintiff had been discharged for cause. But both that evidence and the court's conclusion were at odds with the undisputed evidence of the plaintiff's excellent work record. The court reversed, holding that in light of the evidence as a whole, the statement that there was no discriminatory intent was objectively not credible. The operative rule was explained by the Seventh Circuit in another case, *Hagge v. Bauer,* 827 F.2d 101 (7th Cir. 1987), where it wrote [at 105-06]:

> "When findings are based on determinations regarding the credibility of witnesses, Rule 52(a) demands even greater deference to the trial court's findings; for only the trial judge can be aware of variations in demeanor and tone of voice that bear so heavily on the listener's understanding of and belief in what is said. (citation omitted) This is not to suggest that the trial judge may insulate his findings from review by denominating them credibility determinations, for factors other than demeanor and inflection go into the decision whether or not to believe a witness. Documents or objective evidence may contradict a witness' story; or the story itself may be so internally inconsistent or implausible on its face that a reasonable factfinder would not credit it. Where such factors are present, the court of appeals may well find clear error even in a finding purportedly based on credibility."

In order for there to be a consistent application of the rules of appellate review, the foregoing rule should have been applied to the case at bar, for no generally exculpatory testimony can mask the conclusion mandated by the basic facts presented by this record, that at the very least, Dr. Cohen was negligent in his treatment of Joseph at the critical time when he first began to present symptoms of the pre-acute stage, on Saturday night.

The district court found that ischemia is hard to diagnose – but it had already been diagnosed. All Dr. Cohen had to do was watch for any change and then follow his instructions to notify

the more experienced physicians on the team. He failed to do this. There is no witness who directed his attention to that conduct and was able to say that it was *not* a breach of standard of care. Only two doctors considered it specifically: Dr. Bennett and Dr. Littooy. Dr. Bennett said it was strong negligence, [R.217, vol.II] while Dr. Littooy stated that it would be a mistake to watch a patient with CMI until there were objective abdominal findings before being concerned about him being in the acute phase [R.41, vol.I], and if there was any change Dr. Cohen was to notify Dr. Littooy. Yet it is undisputed that Dr. Cohen was negligent in doing the former and failing to do the latter. The Seventh Circuit specifically found that it was negligent for Dr. Cohen not to call the attending doctor, Dr. Littooy at 6:00 a.m. on Sunday morning, when the vital signs began to change, but that's the indication that the condition is becoming acute. What possible reasonable or logical basis can there be for the Seventh Circuit not finding that it was negligent for Dr. Cohen to fail to call Dr. Littooy on Saturday night?[6] There is no question that a surgical intervention at that time would have saved Joseph's life, there is no question that Dr. Littooy relied on the Hines V.A. staff to advise him of any changes, there is no doubt that there were changes and that Dr. Cohen noted them, there is no doubt he failed to advise Dr. Littooy of these changes, and there is no doubt that he spent the evening treating Joseph for ulcers, a condition for which he was not hospitalized and for which he was not making a presentation. There is no doubt that Joseph was making a classical text-book presentation of the pre-acute phase, there is no doubt that this was the "golden moment" for surgical intervention, there is no doubt that Dr. Cohen was incapable of performing this surgery and moreover, there is no doubt that there was no available operating room in the hospital for a qualified doctor to perform it.

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[6] Especially if one operates from the premise adopted by the district court: that things "started to happen" at 1:30 a.m., and the surgery should have been commenced at 2:00 a.m. [App. 19]

Indeed, if it is possible at all to fairly read Dr. Weigelt's testimony as constituting a statement that there was no negligence on Defendant's part, then it is surely internally inconsistent and self-contradictory. For Dr. Weigelt testified clearly what must be done the moment it is suspected that a CMI patient is going acute. If the doctor is unsure of the source of the pain, as Dr. Cohen was, he must be willing to pursue the problem aggressively, [R.437-38, vol.III] without waiting for more positive signs to develop because it is precisely during this period of observation that the opportunity to save the patient may be lost. [R.438, vol.III] He indicated that by the time the tell-tale signs of peritoneal irritation become evident on abdominal palpation, or the x-ray is positive for ischemic bowel, intestinal necrosis usually has developed, drastically reducing the patient's chances of survival. [R.438, vol.III] He further stated that acute, *severe abdominal pain in the absence of other abdominal findings is often the clearest sign of early pre-infarction ischemia indicating the golden moment for aggressive intervention.* [R.439, vol.III] Dr. Weigelt's specific testimony is clear.

The actual medical testimony makes it absolutely clear that there was no scientific basis for Dr. Cohen's conduct on Saturday night and early Sunday morning in pursuing the imaginary diagnoses of a perforated peptic ulcer or cardiac condition. All the medical evidence indicated that, had he had a perforated peptic ulcer, Joseph's abdomen would have been like a board, rather than soft, as it was. [R.304, vol.II] Therefore there was no basis for treating him for perforated ulcers. Moreover, the treatment given, Mylanta, was not the established treatment for the condition even if it had been a perforated ulcer. [R.236-37, vol.II] He had been cleared from a cardiac standpoint for major surgery. But, and this is what is most important, Dr. Cohen was not instructed to endeavor to work out a course of treatment for this complicated case, but to notify his superiors of any change in condition, which he failed to do. [R.43, 60, vol.I]

Further, it was undisputed that there was a change in Joseph's condition the evening of April 27, with the onset of sustained and much more severe pain, which was an entirely

new finding, consistent with a diagnosis of an acute abdomen, according to Dr. Littooy. [R.118, vol.I] Moreover, this pain occurred when Joseph was not eating, which again, indisputably would indicate not CMI but AMI. [R.134-35, vol.I, 332 33, vol.II] The pain was so severe that, for the first time ever, he required strong, narcotic pain medication, which didn't even completely relieve his pain. [R.33-38, 47-50, vol.I] It is uncontradicted that this constituted a change in condition; it is uncontradicted that Dr. Cohen was supposed to notify his superiors of any change, and it is uncontradicted that he did not do so.

The Seventh Circuit endeavors to deal with these facts by observing that leaving Joseph in the hands of an intern was "questionable," but even the other doctors agree that they would not have "diagnosed the acute condition" prior to 6:00 a.m. [App. 6] The implication presumably is that the intern's inexperience is of no moment, since even an experienced doctor would not have made the diagnosis until the next morning. This dove-tails with the district court's finding that by 6:00 a.m. it was already too late to save the patient, so that the twelve hours of neglect and bumbling which followed didn't really make any difference to the outcome. And yet no witness testified that it was too late to save Joseph at 6:00 a.m. Certainly no witness testified that the condition went from pre-acute to acute at 2:00 on Sunday morning, the district court's critical finding needed to back into its conclusion that the bowel was past saving by 6:00 a.m. (The Seventh Circuit didn't even want to comment on this bizarre finding) But most importantly, both the Seventh Circuit and the district court labored not only to decide the issue wrongly, but even decided the wrong issue. For while twisting and turning to find ways to excuse the Respondent's conduct after the acute phase had been entered, neither court even addressed the issue of a breach of duty for failing to act properly during the *pre-acute* phase, that time before the ischemia becomes acute and the race with the clock to save the bowel even begins, that time which Respondent's own witness described as the golden moment for intervention.

No witness testified that the condition had not entered the pre-acute phase on Saturday night, and no witness stated that Dr. Cohen's handling of the situation was within the standard of care – Dr. Bennett said it was strong negligence and Dr. Littooy said that such conduct would be a mistake. Nor can the situation be saved by Dr. Weigelt's general conclusion that there was no breach of duty. Why? Because Dr. Weigelt believed that the acute stage had not even begun until late on Sunday morning and that an operation starting as late as noon might have saved Joseph's life. Accordingly, his frame made what happened on Saturday evening less important since there would be plenty of time to act on Sunday morning. In making his assessment of the duties devolved on Dr. Cohen, Dr. Weigelt proceeded on the premise that the crisis would not be reached for another 18 hours, not that by 6:00 a.m. the bowel would be already past saving. It is this sort of misreading that Petitioner had in mind when she stated that the determination by the district court was unjudicial. What the district court has done, and the Seventh Circuit has affirmed, is not to make an evaluation as to credibility or weight to be given to the evidence of the various witnesses, but to take little portions of the testimony of differing ones and re-combine them in a way which represents the opinion of none of them, and to thereby reach a conclusion to which no witness testified. If we are going to take Dr. Littooy's opinion that there was an emergency at 6:00 a.m., and add to it the trial court's own adjustment that this really means that the bowel was already lost by that time and that the surgery needed to be started four hours *earlier*, then we cannot exculpate the failure to start the surgery by that time by reference to the testimony of another witness who gives an opinion as to standard of care for that night based upon the view that the surgery could have safely been begun a half day *later*.[7] Accordingly, the district court's

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[7] This is not to say that Dr. Weigelt ever actually testified that Dr. Cohen had not been negligent with respect to his handling of the case on Saturday night. Neither he nor anyone else ever actually gives that testimony.

use of the evidence is, Plaintiff submits, unjudicial: it is irrational and fallacious; it wants the essential logic which is the requirement of all valid inferences. None of the manipulation of times for the condition becoming acute can alter the fact that Joseph spent the whole night in the pre-acute stage (albeit in a hospital that had closed its operating room for repairs), and that last clear chance to save his life, was spent giving him Mylanta, an over-the-counter antacid.

But none of this is addressed in the Seventh Circuit's order, which it did not wish to publish. The Circuit Court's reticence to publish more about how veterans are treated in Chicago-area V.A. hospitals is understandable, since only a few months before the same Court had to reveal the shocking indifference of veterans' hospitals in the Chicago area.

In *Murrey v. United States,* 73 F.3d 1448 (7th Cir. 1996), the evidence showed that the plaintiff's decedent had been allowed to bleed to death while in the hospital for post operative care due to a delay in taking him to surgery because no operating rooms were available. Judge Lindberg, who was the trial judge in this case also, found that there was no negligence based upon expert testimony that there was no requirement for a hospital of that kind (one which did not have a trauma center) to be able to perform emergency surgery. Considering the evidence as a whole, and particularly given the type of patients who were treated there, a different panel stated that it could not conceal its skepticism. [*Id.* at 1455] While the presence of a significant evidentiary error relieved the Court of the necessity of making a holding upon the issue, it stated that it suspected that the finding that the delay in getting Murrey to an operating room was not negligent was clearly erroneous. [*Id.* at 1455]

Throughout this case efforts have been made to minimize the dangers presented by leaving Ulczycki, in his precarious condition, in a hospital that didn't have an operating room by pointing to the testimony of how easy it is to move the patient to another hospital. But in fact, in the case at bar, from the time it was decided to do the surgery it took four hours to get Ulczycki to an operating room – enough time to have revascularized the bowel. To the district court and the Seventh Circuit none of that matters because, if you wait long enough,

nothing matters. Yet, the decision in the case at bar is entirely inconsistent with the Seventh Circuit's decision in *Murrey*, where it was held that hospitals could not excuse themselves for failing to provide operating facilities, and that the Court was not bound to accept patently unreasonable positions even if testified to by witnesses at the behest of the hospital. The case at bar entirely violates the spirit of that decision. Society is asked to accept that there was nothing wrong in delaying Ulczycki's surgery until it was too late, even though he had been in the hospital for a week. Every bit of evidence is strained and tortured to produce this result, but even at that the decision is illogical and fails to account for the actual evidence in the case. For in reality, if the evidence is examined logically, there is no evidence which supports the pivotal joint findings that at 6:00 a.m. Ulczycki's condition turned acute *and* that, therefore, there was nothing further which could be done for him. Dr. Bennett's testimony, of course, is entirely to the contrary and does not support the finding in any way. Dr. Weigelt testified that, in his opinion, at 6:00 a.m. the crisis had not yet even been reached, and a life saving operation was possible as late as noon. That leaves Dr. Littooy. No fair reading of his testimony can be said to support the finding that nothing further could have been done. The record is clear. Judge Lindberg asks him plainly: "With regard to the vital signs at 6:00 a.m. on the 28th, had you been physically there and observed those, or someone called them to you, would that have caused you sufficient concern to begin the steps toward surgery at that point rather than waiting until 2:00 in the afternoon?" To which Dr. Littooy answers: "Yes, that would have." [R.167, vol.I] Now, reasonably considered, how does that testimony support the finding that the bowel was past saving at 6:00 a.m.? In no way. On the contrary, it doesn't even support a finding that infarction had begun, it only supports a finding that there was an emergency at that time. But Judge Lindberg's questions continue: "And do you think that there would have – in your expertise, do you feel that that would have altered the patient's likelihood of survival?" To which Dr. Littooy responds: "That's not any easy question." [R.167, vol.I] Perhaps not. And the fact that it is not an easy question

may excuse Dr. Littooy for not having an opinion to express with respect to it, which he certainly never did. But his failure to have an opinion cannot be parlayed either into constituting evidence that immediate action at 6:00 a.m. would have been unavailing or into contradicting the other evidence in the case. But Dr. Littooy continued his answer, so in fairness let's see what he testified to next. "But as I say, the other thing that has to be factored into all of this, even if we had gotten in there at *10:00* in the morning, for instance, is that it takes four to five hours at best to revascularize the bowels. So we are still looking at least at another four to five hours of ischemia time." [R.167, vol.I; *emphasis added*] What does 10:00 have to do with anything? The issue is whether the bowel was too far gone at 6:00 a.m. (at which time the Circuit Court found that it was negligent for Dr. Cohen not to notify Dr. Littooy) or whether prompt action at that time would have saved enough of the bowel to save Ulczycki's life. Dr. Littooy's testimony as to what would have happened if prompt attention had been given at 10:00 a.m. is irrelevant to the findings about Ulczycki's condition four hours earlier, particularly since the revascularization part of the surgery can be completed in as few as four hours.

Considering all this, the Petitioner respectfully submits that it is impossible that judgment for the Respondent could be given or affirmed in the absence of a mistake. As for the actions of the district court, findings were made for which there was absolutely no evidence (such as the finding that the surgery needed to be started by 2:00 a.m.); findings were made which have no rational basis in the relevant evidence (such as using Dr. Littooy's testimony as a basis for finding that the bowel was past saving as early as 6:00 a.m.); and findings which ignore whole bodies of uncontradicted evidence (such as finding that there was no negligence without giving any consideration to the entire matter of the pre-acute phase). Accordingly, the Seventh Circuit misunderstood and misapplied this Court's holding in *Anderson v. City of Bessemer*, 470 U.S. 564 (1985), when it applies it to justify an affirmance in the circumstances of such a case as this. The Seventh Circuit's order is also entirely contrary to the well-established rules for

appellate review expressed in such cases as *Pendleton v. Pan American Fire and Casualty Co.*, 317 F.2d 96, 101 (10th Cir. 1963), *Lame v. United States Department of Justice*, 767 F.2d 66, 70 (3d. Cir, 1985), and *Legrand v. Trustees of University of Arkansas*, 821 F.2d 478 (8th Cir. 1987). Nor are the Seventh Circuit's own findings rationally supported by the record. The Seventh Circuit endeavors to lend some degree of reasonableness to the district court's findings by misreading Dr. Bennett's testimony that Joseph would have survived if the surgery had been done by 9:00 a.m. to mean, not commenced by that time, but completed by that time. The Court states that the word is ambiguous, and the district court could take it either way. Petitioner disagrees. The Seventh Circuit and the district court alike share the duty to understand the evidence considered as a whole, not to divorce one sentence from an entire examination. In fact, the Seventh Circuit's expedient is entirely contradicted by the rest of the testimony of Dr. Bennett, especially on cross-examination, where he stated that, in his opinion, 2:00 p.m. on Sunday would have been too late to save Joseph, noon was possible, while an operation begun at 10:00 would have been much better. [R.270, vol.II] Equally inappropriate is the Seventh Circuit's resolution of the issue created by the unconscionable delay in scheduling the operation, by treating the condition as elective when even the district court had found that it was urgent. The Seventh Circuit stated that epidemiological evidence would be required to determine the issue. There is, however, nothing to suggest that such evidence even exists, since it is not the practice to allow CMI patients to go uncorrected to see how long they survive without treatment. Moreover, the evidence in the case at bar was conclusive that Joseph's case was the worse case of CMI that these doctors had seen. Accordingly, statistical evidence with respect to CMI generally would not have been relevant to the standard of care *in this case*. Hence there is no factual basis for the Seventh Circuit's finding. As a matter of law, Petitioner submits that the Seventh Circuit had no more right to raise a new theory of evidence on appeal than did either of the parties. There was ample evidence to establish that the surgery should not have been delayed. It was Dr. Tattersall, one of the treating doctors,

who stated that they were taking a calculated risk but never indicated how it was calculated. Certainly such evidence cannot rightly support a finding in Respondent's favor. This Court is authorized to use its supervisory authority to reverse the judgment of the district court and the Seventh Circuit's affirming order, to both correct the very substantial injustice accomplished in this case as well as assuring that the standards of review will be consistent between the Circuits and conform to the requirements of this Court.

CONCLUSION

For the foregoing reasons, Petitioner Ann R. Ulczycki respectfully requests that the Court grant her Petition for a Writ of Certiorari.

Respectfully submitted,

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UNITED STATES COURT OF APPEALS

For the Seventh Circuit
Chicago, Illinois 60604

Argued June 4, 1996

June 12, 1996.

Before

Hon. WILLIAM J. BAUER, Circuit Judge

Hon. RICHARD D. CUDAHY, Circuit Judge

Hon. FRANK H. EASTERBROOK, Circuit Judge

ANN R. ULCZYCKI, Executor of the Estate of Joseph Ulczycki, *Plaintiff-Appellant,*	)	Appeal from the United States District court for the Northern District of Illinois, Eastern Division.
No. 96-102 **v.**	)	No. 94 C 7807
UNITED STATES OF AMERICA, *Defendant-Appellee.*	)	George W. Lindberg, *Judge.*

Order

Joseph Ulczycki, 69 years old, was admitted to the Hines Veterans Administration Hospital on April 14, 1991, with nausea, abdominal pain, and bloody diarrhea. A heavy smoker, Ulczycki had a history of coronary artery disease (and other vascular difficulties) and peptic ulcers. Endoscopic examination revealed inflammation and ulcerations; a physician prescribed acid-suppression medication. Ulczycki was released on April 19 after the symptoms abated. Two days later, he was back with abdominal pain and nausea. The recurring symptoms led

attending physicians to suspect a deficiency in mesenteric blood supply.

On April 24 the Hospital performed an angiogram, the best diagnostic tool for vascular problems of the bowel. For people in Ulczycki's condition, the mortality rate from this procedure is three to five percent. Ulczycki survived and was diagnosed as suffering from chronic mesenteric ischemia: blockage of the arteries supplying blood to the lower intestine. All three of the major arteries were occluded, but the physicians believed that collateral blood supply was well-developed.

Surgery to revascularize the intestines lasts five to eight hours and is very risky for someone in Ulczycki's condition. Before they would consider performing this surgery, physicians ordered cardiac studies, seeking to learn whether Ulczycki could stand the procedure. A cardiac stress test was administered on April 26, and Ulczycki's performance led Dr. Fred Littooy, chief of peripheral vascular surgery at the Hospital, to conclude that a revascularization operation could succeed. The operation was scheduled for Tuesday, April 30.

Obstruction of the collateral blood sources turns chronic mesenteric ischemia acute. Deprived of blood, the lower intestine dies in approximately six hours. That is roughly the time it takes to perform the operation, so unless the acute phase is detected almost immediately, it is impossible to save the organ – and, as there is no substitute for a lower intestine, impossible to save the patient's life. Dr. Littooy told Dr. Michael Cohen, a first-year intern, to monitor Ulczycki over the weekend and relate any substantial changes in his condition. At 6 p.m.

on Saturday, April 27, Ulczycki reported sharp abdominal pain and tenderness, symptoms that could represent a flareup of peptic ulcers or a reduction in blood flow. Cohen believed that ulcers were at work and prescribed an antacid; later he prescribed a painkiller.

Throughout the evening of April 27 and the early morning of April 28, Ulczycki's vital signs were stable and close to his norms. Beginning at 6 a.m. on April 28, Ulczycki's temperature, blood pressure, pulse, and respiration increased sharply. By that afternoon, it was clear from both his vital signs and an x-ray taken about 10:30 a.m. that Ulczycki's condition had entered the acute stage. Dr. Littooy was summoned, and Ulczycki was in the operating room (at Loyola University Hospital, across the street) by 5:30 p.m. Littooy found the bowel dead. Ulczycki died at 4 a.m. on April 29. His estate filed this suit under the Federal Tort Claims Act, contending that the chronic mesenteric ischemia should have been detected earlier, that surgery should have been completed before April 27, and that the staff was in any event negligent when matters degenerated on April 27 and 28.

Immediately after the end of a bench trial, the district judge ruled for the United States. The judge concluded that the decision not to perform an angiogram during the first admission was not negligent, that the physicians acted prudently in doing a cardiac workup after the diagnosis of chronic mesenteric ischemia, that Ulczycki's condition did not appear to be so serious on April 26 that immediate surgery was imperative, that careful physicians would have diagnosed acute mesenteric ischemia no earlier than 6 a.m. on April 28, and that by then even immediate surgery would not have succeeded – making

irrelevant the fact that surgery did not commence for 12 hours. The estate appeals. We affirm, because none of the findings and inferences can be called clearly erroneous. *See Anderson v. Bessemer City*, 470 U.S. 564 (1985).

If an angiogram had been performed during Ulczycki's first stay at the Hospital, revascularization would have been accomplished before the condition became acute. Testifying as the estate's expert witness, Dr. Kenneth Bennett opined that it was negligent to discharge Ulczycki without performing an angiogram. All of the attending physicians, plus Dr. John Weigelt, a surgeon on the faculty of the University of Minnesota, disagreed. These witnesses believed that an angiogram is sufficiently risky, and chronic mesenteric ischemia sufficiently rare, that the procedure is not justified unless the symptoms persist and other options have been ruled out. The Hospital's attending gastroenterologist added that the endoscopy findings did not depict a classic presentation of chronic mesenteric ischemia. The distict judge accepted this view, as he was entitled to do.

Dr. Bennett conceded that Ulczycki was too dehydrated on his second admission to perform an angiogram until April 23. The district judge accepted testimony of the defense witnesses that it was prudent to wait until April 24, after which still more time passed during the cardiac workup. Because Dr. Littooy concluded that surgery was not urgent, and therefore set the operation for his next regular surgical day at the Hospital (April 30), it made no difference whether the angiogram was done on April 23 or 24; surgery would have been scheduled for April 30 anyway.

Was that scheduling decision itself negligent? All witnesses agreed that acute mesenteric ischemia is very likely to be fatal, so surgery is indicated following a diagnosis of chronic mesenteric ischemia. But how soon is the condition likely to become acute? One year plus or minus six months? One month plus or minus one week? One week plus or minus four days? These imply very different schedules. If a patient in Ulczycki's state ordinarily has a six-month period of safety (though discomfort), then it makes sense to do the surgery in the regular course – for the work of a rested surgeon, collaborating with the regular surgical team, is more likely to succeed than is a rush job. An eight-hour operation is not performed on the spur of the moment except in an emergency. But if a condition such as Ulczycki's was likely to become acute within days, then it would have been negligent to delay surgery as Dr. Littooy planned to do.

Unfortunately, the record does not contain any epidemiological data from which the court could have made this judgment. What it does contain is the competing beliefs of Drs. Bennett, Littooy, and Weigelt. Bennett thought the condition urgent; Littooy and Weigelt thought that Ulczycki was stable, with well-developed collateral blood supply, and therefore not at immediate risk. With benefit of hindsight, we know that the risk was greater than Dr. Littooy thought at the time (or perhaps the risk was small, but Ulczycki was an outlier in the statistical distribution). But the district judge did not commit clear error in accepting the testimony of Drs. Littooy and Weigelt that the short-term risk as it was knowable at the time appeared low, making it advisable to operate in the regular course rather than immediately.

That leaves only the question whether the Hospital should have taken Ulczycki's pain on April 27 as the sign of an impending (if not actual) acute condition, rather than as a flareup of his ulcers. All of the physicians agreed that it is very hard to diagnose the acute state, so leaving matters in the hands of an intern was questionable. But the more experienced physicians (other than Bennett) testified that, had they been on the scene before 6 a.m. on Sunday, they would not have diagnosed the acute condition.

Littooy testified that he would have begun an operation as soon as possible after Ulczycki's vital signs shifted at 6 a.m. on April 28. We may assume that Cohen was negligent in not informing Littooy immediately of this development. But the district judge found, again with support in the record, that by 6 a.m. it was too late. When acute mesenteric ischemia sets in, death is almost certain; that is why the estate stresses the need for emergency surgery after a diagnosis of chronic mesenteric ischemia. Dr. Bennett testified that if an operation had been "done" by 9 or 10 a.m. on April 28, Ulczycki might have survived. The estate argues on appeal that this means that the Hospital had three to four hours to save Ulczycki and should have begun the operation immediately. The district court apparently understood "done" to mean "completed" – for until the end of the operation, no blood is supplied to the bowel. Notice at 6 a.m. could not have led to an operation completed by 10 a.m. under any circumstances. The district court's understanding of "done" is consistent with other uses of that word in the record; and

at all events one reading of an ambiguous word over another cannot be called clearly erroneous.

AFFIRMED

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF ILLINOIS

Eastern Division

Ann R. Ulczycki, Executor of the Estate of Joseph Ulczycki, Deceased,

-VS-

United States of America

JUDGMENT IN A CIVIL CASE

CASE NUMBER: 94 C 7807

[ ] Jury Verdict. This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.

[X] Decision by Court. This action came to trial before the Court. The issues have been tried and a decision has been rendered.

IT IS ORDERED AND ADJUDGED judgment is entered in favor of the defendant United States of America and against the plaintiff Ann R. Ulczycki, Executor of the Estate of Joseph Ulczycki, Deceased.

December 1, 1995
Date

H. Stuart Cunningham
Clerk

/s/ Sandra Brooks
(By) Deputy Clerk

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

ANN R. ULCZYCKI, Executor of the Estate of JOSEPH ULCZYCKI, Deceased, Plaintiff, vs. UNITED STATES OF AMERICA, Defendant.	No. 94 C 7807 219 South Dearborn Street Chicago, Illinois 60604 Wed., November 29, 1995 9:30 o'clock a.m.

VOLUME III

TRANSCRIPT OF PROCEEDINGS

BEFORE THE HONORABLE GEORGE W. LINDBERG

(Filed Dec. 29, 1995)

APPEARANCES:

For the Plaintiff: KEITH A. HEBEISEN, Esq.,
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For the Defendant: EILEEN M. MARUTZKY, Esq.,
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219 South Dearborn Street
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[p. 498] THE COURT: All right. Let me ask counsel for both sides whether or not I have now heard

all the evidence or read – I have the radiologist's deposition which I have absorbed, and I have the exhibits that were referenced here in court.

[p. 499] And I have the medical record which I followed on a page by page basis, and I have the CV's, and the Government "F" which I think is – my copy is a little hard to read, but it's the scan on April 24th.

MR. HEBEISEN: You mean the report.

THE COURT: Yes.

MR. HEBEISEN: Okay.

THE COURT: Which I have – from Doctor Ramamurthy.

MR. HEBEISEN: Easy for you to say.

THE COURT: Now, is there anything else that –

MR. HEBEISEN: I just want, for the record, your Honor – we also listed on the pretrial order, the plaintiffs did, the death certificate. I know it's not in controversy.

THE COURT: No.

MR. HEBEISEN: I think that's a detail. His administrative file, which I don't think we ever ended up referencing, the tax returns which I would like to submit, if your Honor wants to take a look at those, the funeral bills, the family photos you have, I believe, which were Exhibit 8.

THE COURT: Yes.

MR. HEBEISEN: Could I exchange lasers of those.

THE COURT: Yes, definitely. As a matter of fact, I have them in mind. I don't need copies of them now.

Let me just suggest that I probably will never be in a better position to discuss the evidence than I am right [p. 500] now, so I would be ready to rule if the parties find that I have, in fact, seen everything that I am supposed to see.

MS. MARUTZKY: Yes, your Honor, as far as the Government goes.

MR. HEBEISEN: I would agree with that, your Honor.

THE COURT: All right. Let me begin then by indicating that some of these types of cases – and I'm referring to those which we see, because they originate in the VA system – are not difficult. You hear the evidence, and it turns out that they are rather easily decided; not that I've had that many, but some of them are difficult, and this falls into the difficult category.

I don't have any particular methodology to discuss the evidence. I think what I will try to do is follow the time line of the events here, noting that the – and I'm going to refer to him as the patient – had a compromised vascular system which has been testified to by everybody, and had had the previous surgeries that had been discussed, and had a medical record with which the physicians were familiar once he was admitted on the first admission in April of 1991.

It appears that the physicians – Doctor Cohen, Doctor DeMeo, Doctor Neal, during that admission – I think I've

got the right doctors for that – but, anyway, the physicians, based on the notes introduced here in evidence, [p. 501] seems to have followed a standard technique for the differential diagnoses that are required in order to know what condition to treat, or what conditions to treat.

He had a history of gastrointestinal difficulties, so there was nothing apparently outstanding that should have, in the Court's view of the evidence, directed them immediately or even early onto the chronic mesenteric ischemia that ultimately was diagnosed the following week.

Now, let me just address at this point the witnesses that we had. I think counsel wastes a lot of time when they attack the bona fides of the particular witnesses.

Obviously, people call witnesses who have reviewed the evidence and find their respective positions sustainable. I doubt very much if you would get anybody in here that didn't feel that way.

As a matter of fact, that was the view expressed by one of the witnesses – one or more of the witnesses.

It's the Court's view that the witnesses are completely truthful and honest in their view of this evidence.

I do not subscribe to any particular attack on either Doctor Bennett's motives, or Doctor Tattersall, Doctor Littooy, Doctor Cohen, Doctor DeMeo, and anyone else we had up here – who escapes me at the moment – Doctor Weigelt.

So I put that aside. I think they are completely [p. 502] truthful in their testimony.

I do find a distinction between the quality of the evidence of Doctor Bennett and that of each of the others.

I was not quite as impressed with the quality of the testimony of Doctor Tattersall as I was with the other witnesses – Doctor Cohen, Doctor DeMeo.

In particular, Doctor DeMeo and Doctor Littooy were not only honest, as I indicated with regard to Doctor Bennett, as well, but I thought their testimony was more incisive and more persuasive to the Court.

Therefore, when Doctor Bennett testified that he wouldn't have released Mr. Ulczycki at the end of the first week without having performed an angiogram, I am not satisfied that Doctor Bennett is sufficiently knowledgeable.

Let me say he was extremely knowledgeable about the record in this case. There is no question, he knew this record as well as anybody. But I'm not persuaded that he has his hands in the gut, if you will, as – to the extent that the other witnesses did. And even not cumulating their testimony, I found that Doctor Weigelt and Doctor DeMeo and Doctor Littooy were particularly persuasive.

So I tend to discount the significance of any malpractice or falling below the standard of medical care during that first admission.

The next event probably occurred after his [p. 503] readmission on Sunday, and he went through, I would say, a period of recuperation from his extremely sharp and painful circumstances precipitating his return to the hospital.

They appear to have treated him well on Monday and Tuesday without any testimony, I think, even by Doctor Bennett that the treatment that was afforded him on those – on the admission on the Monday and Tuesday were appropriate.

Again, Doctor Bennett maintains that he should have had that angiogram not only the previous week, but now that he's back, he should have had it sooner than he did by a day or two.

There was testimony, I think, by Doctor DeMeo who felt that he was simply too sick to undergo rather significant procedures.

In the meantime, on Tuesday, I believe they had the g.i. peripheral vascular consult which resulted in the Wednesday angiogram, and ultimately the Friday cardio work-up in anticipation of surgery which became indicated in the opinion of everyone but Doctor Bennett on Tuesday – on the day of – not Tuesday, on Wednesday, the day of the angiogram.

So I don't see that the standard – I'm not persuaded that the standard of care was breached from the Sunday through the taking of the angiogram, which everybody now acknowledges was the gold standard for this particular [p. 504] diagnosis, for diagnosis of chronic mesenteric ischemia.

I think at this time, I have to comment on the fact that I think at all times, we have to keep in mind that he had a seriously compromised vascular system, and under those circumstances, apparently based on the testimony of

these people, including Doctor Bennett, there is lots of things that can happen when you are so compromised.

Interestingly, nobody made any particular comment about the cigarette smoking, other than noting that it was one of his health habits. I don't even know if he was still smoking at the time of these proceedings.

But in any event – and disregarding that – the fact is that he was compromised, and he was in severe pain and – I wanted to make mention of some other – oh, and I think of great significance in the case was that his vitals and his labs tended to fluctuate with peaks and valleys which, while it may also indicate a chronic mesenteric ischemia, apparently is consistent with other conditions, and certainly did not – would not precipitate a diagnosis of acute mesenteric ischemia.

So, again, up to the point of the angiogram and, frankly, at that point, when they decided that there was to be surgery, again, other than Doctor Bennett, it does not appear that it is below the standard of care to schedule a patient with that condition for surgery on an urgent basis [p. 505] but not on an emergency basis.

I'm sure Mr. Hebeisen takes great issue with that, and I think in retrospect, all of us would, but I don't know – and there was no testimony – that every time you get a diagnosis of chronic mesenteric ischemia, that you must operate instantly.

There was no testimony from anyone that I know of, and I'm not sure Doctor Bennett persuaded me that that was his view.

I know counsel for the Government tended to deride Doctor Bennett who would apparently do all of the most invasive procedures, and so forth, based on the Government's interpretation of Doctor Bennett's testimony.

In other words, the devil take the high most, we will do all these procedures, regardless of the condition of the patient, and regardless of whether or not the procedure is sufficiently invasive as to precipitate its own death – I don't want to say death defying act, but procedure leading to death.

I mean, it's common knowledge that – and the Court can take judicial notice – that angiograms are very serious conditions, and have led to death themselves, just doing that diagnostic technique.

And here we have someone with a considerably compromised vascular system, one that has persisted [p. 506] sufficiently long that the celiac and the superior and inferior mesenteric arteries have been compromised, and the femoral artery had developed in such a way as to provide collateral blood supply.

So things have been going on there for a long time. I think this is a patient you treat with kid gloves based on my assessment of the evidence.

So getting back to the procedures taken after the identification of – or the diagnosis of the chronic mesenteric ischemia, and with Doctor Littooy on the staff who is obviously quite familiar with this type of surgery to the extent that it occurs – and that's another point that should be made.

It seems to me not unreasonable to delay an invasive process such as an angiogram when statistically this condition is low on the index or the inventory of diseases.

Here we have experts, including – I should say medical doctors, including Doctor Bennett, none of whom seem to have seen more than a dozen of these and, in some cases, only five and so forth, in spite of their extensive practice.

So it's a rare condition with a very invasive diagnostic resource to confirm it, the so called gold standard of diagnostic procedures.

So I don't think that there was anything below the standard of care in scheduling him for the following Tuesday, [p. 507] when he would have what appears to be the top man in this type of surgery available at Hines.

I think the question as to whether it should have been done during his day at Loyola on Monday is now academic. But, in any event, I don't think we can consider whether or not other people were scheduled and would have had to have been rescheduled. I didn't hear any evidence to that effect. So I disregard anything about that.

But taking whatever steps were necessary to treat a nonemergency condition, and until we get to 6:00 a.m. on Sunday morning, the 28th of April, 1991, we don't have, the Court finds, an emergency situation.

We have a situation that is – should be addressed, but there is no indication that it has to be addressed in other than the ordinary course of hospital business, and that there was no indications, contrary, in the Court's view, to

Doctor Bennett's testimony, that they had to do anything other than schedule as they did.

Finally, we get to – and the Court's view on the time line here – we get to April 28th, 1991, at 6:00 a.m., when the numbers are beginning to show an ongoing, or the onset of serious difficulty most likely arising from what they now know, and have known since Wednesday, was the chronic mesenteric ischemia. I think I keep pronouncing that wrong – ischemia.

[p. 508] And probably the most serious question posed in this case, and which Mr. Hebeisen addressed most recently in his closing but, particularly, in his rebuttal, is whether or not they should have proceeded instanter – stat, to use the medical terminology – to call everybody in and get this fellow to surgery right then and there.

I presume that that would probably get him on the table at 9:00 or 10:00, maybe even earlier. I'm just not sure.

Obviously, it wouldn't have been at the VA because of the boiler shutdown, but just it's just a matter of minutes to get him across the street or, at most, an hour apparently to get him across the street to Loyola which, in fact, they did later in that day.

And the conclusion I come to on this most critical question is that the Court is not persuaded that the bowel had not materially changed its condition such that it could be saved if the surgery had taken place at 8:00 or 9:00 Sunday morning, as opposed to 5:45.

We can speculate, we can use Doctor Littooy's figure of six to eight, I think, hours. I think Doctor Bennett said somewhere in the area of six to eight hours. Let's say four to eight was what most of the conversation was.

But the evidence indicated it is an elusive issue as to when the bowel began to die, or when it came to the point [p. 509] where revascularization surgery would not be helpful.

It's just not in the evidence, other than the four to eight hours but, then, as Doctor Weigelt says, you really never know.

We don't know that maybe after 1:30 in the morning, after that visit by, I think, Doctor Cohen – if I'm not mistaken – that things started happening.

So it's problematic, and the Court is not satisfied that it is more likely true than not that surgery earlier in the day, and as early as 7:00 o'clock in the morning, would have saved Mr. Ulczycki's life, or that the result would not have been exactly what it was, some ten or eleven hours later when he was operated on and found to be essentially terminal.

I don't know that there is any necessity to discuss Doctor – the radiologist, I will say – his deposition. I think – I don't see that there is anything controversial about it.

We did have the issue of the viability of the intramural arterial supply by both – well, certainly by the radiologist in his deposition, and the question of whether or not Doctor Weigelt could see viabilities, so to speak, on

these originals of the angiograms that he studied this morning before trial.

The evidence there is just inadequate to sustain a [p. 510] conclusion that there was necrosis or whatever the doctors like to call it – the beginning of a lack of viability.

Again, we have the observation by the radiologist that if that had been the objective, they probably would have put the dye in at a more proximal location to these intramural vessels for that specific study.

But that wasn't the overall objective of the study, and apparently neither the abdominal nor the pelvic pictures that he took.

Let me make sure I've covered all the things that I wanted to cover.

And I don't mean to dismiss the fact that there was good reason for the survivors and for counsel to feel that there was something less than perfection in this case. Obviously, substantially less.

I didn't mention the portal vein gas, of course, that was observed from the studies by Doctor Tattersall on Tuesday, on the 28th. I don't mean to ignore them, but they certainly added an exclamation mark to the – to the results of the 6:00 a.m. numbers and – but indicated that as early as that date, death had begun or gone even further than that, so far as we know.

Again, it appears from the evidence taken as a whole that it is extremely difficult to say when Mr. Ulczycki's condition became irreversible through the use of the [p. 511] revascularization procedure.

I think the best that anybody was able to tell us, at least as far as the Court being persuaded in making a finding, is that it more than likely happened on the 28th, and probably, in the Court's view, sometime after 1:30 in the morning, and was in full – full play by 2:00 or 2:30 in the afternoon.

I don't know that I can say anything more about it other than just regurgitating the evidence and telling you what I thought of this, that and the other thing.

But I'm giving you an overview which I think fairly reflects my view of the evidence, and my findings that there was not a breach of the standard of care by any of the physicians or the hospital, and that the Court, accordingly, should enter judgment for the defendant and against the plaintiff.

All right.

By the way, excellent presentations by both sides.

MR. HEBEISEN: Thank you, your Honor.

THE COURT: I'm sure that doesn't mean that much, but it's good to hear good attorneys work.

Now, I'm not going to issue any further analysis, so if you – you may want to order a copy of the record for any appeal that you are going to take.

MR. HEBEISEN: Thank you, your Honor.

[p. 512] MS. MARUTZKY: Thank you, your Honor.

(Proceedings concluded.)

[p. 513] CERTIFICATE

I HEREBY CERTIFY THAT the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

/s/ Richard H. Dagdigian 12/4/95
RICHARD H. DAGDIGIAN DATE
Official Court Reporter

United States Court of Appeals

For the Seventh Circuit

Chicago, Illinois 60604

August 30, 1996.

Before

Hon. WILLIAM J. BAUER, Circuit Judge

Hon. RICHARD D. CUDAHY, Circuit Judge

Hon. FRANK H. EASTERBROOK, Circuit Judge

ANN R. ULCZYCKI, Executor of the Estate of Joseph Ulczycki, *Plaintiff-Appellant,*	Appeal from the United States District Court for the Northern District of Illinois, Eastern Division.
No. 96-1020	No. 94 C 7807
v.	George W. Lindberg, *Judge.*
UNITED STATES OF AMERICA, *Defendant-Appellee.*	

Order

Plaintiff-appellant filed a petition for rehearing and suggestion of rehearing en banc on July 29, 1996. No judge in regular active service has requested a vote on the suggestion of rehearing en banc, and all of the judges on the panel have voted to deny rehearing. The petition for rehearing is therefore DENIED.

Chronology Table

Day	Date	Time	Evidence	Finding
Wednesday	4/24/91		Arteriogram results: poor visualization of vessels. Dr. Bennett and Dr. Weigelt testify the condition is urgent.	District court finds that Joseph's condition is urgent.
Thursday	4/25/91		Nothing is done in connection with Joseph's condition.	
Friday	4/26/91		Cardiac stress test done successfully.	
Saturday	4/27/91		Operating room shut down at Hines VA for weekend. Joseph attended to entirely by doctors in training.	
Saturday	4/27/91	6:00 p.m.	Abdominal pain. Dr. Bennett testifies that the pre-acute stage is beginning. Dr. Weigelt testified that this is when the golden hour for surgical intervention has arrived, and Dr. Littooy states that it would be a mistake to watch for signs that infarction (bowel death) has begun. Dr. Cohen fails to notify Dr. Littooy or any superiors of change of condition; treats Joseph for ulcers.	
Saturday	4/27/96	8:30 p.m.	Abdominal pain continues, Joseph treated for heart condition. Dr, Littooy not notified.	
Sunday	4/28/91	1:30 a.m.	Abdominal pain more severe, but no other symptoms. Joseph is given strong drugs for the pain by Dr. Cohen, who still fails to contact any superior about the change in condition.	District Court finds that the acute stage has begun and that unless surgery had begun by 2:00 a.m. it would be too late late to make a difference.

Sunday	4/28/91	6:00 a.m.	Joseph has fever, tachycardia and tachyphnea, and hypertension. Dr. Littooy states that if he had known about the situation he would have ordered x-rays stat and immediate surgery. Dr Tattersall sees Joseph on his rounds and believed he didn't look that bad. No x-rays ordered; Dr. Littooy not notified of the changes in Joseph's condition.	District court found that the bowel was so far gone that an operation commenced even an hour later would not have helped. Circuit Court found that Dr. Cohen was negligent in not notifying Dr. Littooy.
Sunday	4/28/91	10:00 a.m.	Joseph's respiration is labored: x-rays ordered, but not stat. Dr. Bennett testifies that a surgery at this time would have saved Joseph's life. More pain killers given. Dr. Littooy not notified.	
Sunday	4/28/91	12:00 p.m.	Dr. Weigelt testifies that surgery started at this time could still save the bowel and Joseph's life. Dr. Littooy not notified.	
Sunday	4/28/91	2:00-2:30 p.m.	X-ray results received showing that infarction has begun. Dr. Littooy is notified for the first time. Dr. Tattersall believes that there is now an emergency.	
Sunday	4/28/91	2:00-2:30 p.m.	Dr. Tattersall tries to find a operating room for Joseph at Westside VA.	
Sunday	4/28/91	2:30-3:00 p.m.	Arrangements are made for an operating room for Joseph at Loyola Hospital.	
Sunday	4/28/91	6:05 p.m.	Surgery commenced. Dr. Littooy testifies it is too late to save the bowel.	
Monday	4/29/91	4:00 a.m.	Joseph dies.	